Order Code RL30099

Veterans Issues in the 106th Congress

Updated October 13, 1999

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ABSTRACT

This report focuses on policies, programs, and benefits of interest to veterans. Included are issues before the 106th Congress, and the current status of major legislation. The report is updated from time-to-time to reflect developments in the issues and for actions taken on legislation important to veterans.

Veterans Issues in the 106th Congress

Summary

FY2000 Budget. At the open of the new fiscal year, a Continuing Resolution (H.J.Res. 68) governs funding for the Department of Veterans Affairs (VA). Final Conferees reportedly completed action on October 7th on H.R. 2684, appropriations for VA and other federal agencies; the bill had earlier passed both Houses with similar levels for VA in most spending accounts. The largest discretionary account, medical care, would be provided $19 billion under both versions.

Veterans Benefits Legislation. Both Houses have completed action on a bill (H.R. 2280) to make several benefit changes, along with a Cost-of-Living-Adjustment (COLA) for the compensation and readjustment cash programs. Among changes under consideration are ones which would give eligibility for compensation to surviving spouses of certain deceased former prisoners-of-war who were totally disabled at death; restore eligibility for certain benefits to surviving spouses whose benefits terminated when they remarried; expand authority to raise funds to the American Battle Monuments Commission for speeding completion of the World War II memorial; add to the list of diseases presumed to be service-connected, bronchiolo-alevolar carcinoma so that veterans exposed to radiation who suffer the disease could be compensated; and provide permanent eligibility for home loans to former members of the Selected Reserve. The bill also contains language establishing standards for burial in Arlington Cemetery, similar to the House-passed H.R. 70.

Veterans Millennium Health Care Act of 1999 (H.R. 2116). The House has passed legislation to address issues in the VA medical care system. Provisions of the bill would expand long-term care; increase home health care; give higher priority access to long-term care to severely disabled veterans and to those needing care for service-connected conditions; provide higher priority access to veterans awarded Purple Hearts and certain military retirees; authorize VA to increase copayments for pharmacy benefits used for treatment of nonservice-connected conditions; and authorize emergency care coverage for certain veterans without health insurance. H.R. 2116 also would attempt to structure VA's approach to making major changes in the management of underutilized VA buildings and other capital assets, by setting conditions and limitations upon the disposition of the properties. Provisions similar to ones in H.R. 2116 are also in the Senate-passed S. 1076.

Other Veterans Issues. Legislation has been enacted (P.L. 106-50) to provide expanded Small Business Administration assistance to veterans owning or beginning small businesses. The House has passed the Foster Care Independence Act of 1999 (H.R. 1802), which included language giving Supplemental Security Income (SSI) benefits of 75% the normal rate to certain Filipino veterans who return to the Philippines. These veterans, whose World War II service was in Philippine units under U.S. command, seek broader veterans rights, but other than the improved burial benefits in H.R. 2280, other liberalizations have not been reported from committee. Legislation to establish eight demonstration projects to examine the feasibility of reimbursing VA for medical costs incurred by some veterans with Medicare (called Medicare "subvention") was ordered reported from the Senate Finance Committee, but work on the bill has not been completed in either House.

Contents

List of Tables

Veterans Issues in the 106th Congress

Introduction

Federal policy toward veterans recognizes the importance of their service to the nation, and the effect that service may have on their subsequent civilian lives. The Department of Veterans Affairs (VA) administers, directly or in conjunction with other federal agencies, programs that provide compensation for disabilities sustained in military service; pensions for disabled, poor war veterans; cash payments for certain categories of dependents and/or survivors; free medical care for conditions sustained during military service, and for other conditions under a priority system that results in most care being provided to low income veterans; education, training, rehabilitation, and job placement services to assist veterans upon their return to civilian life; loan guarantees to help them obtain homes; life insurance to enhance financial security for their dependents; and burial assistance, flags, grave-sites, and headstones when they die.

The Veteran Population

There were about 25.2 million veterans as of July 1, 1998, of whom 19.3 million had served during at least one period defined as wartime. The number of veterans is declining, and their average age increasing. The median age of veterans was 57.7 years; 36% were over 65 years of age; about 4.6% were female. The VA projects a decline of about 26% in the number of veterans between 1990 and 2010, down from one of four men in 1994 to one of eight in 2010, half of whom will be over age 62.

Decline in the size of military forces, and the corresponding effect that decline has had on the number of persons entering veterans status, means relatively stable numbers of compensated veterans and fewer veterans seeking readjustment for postservice education and training. The number of disabled wartime veterans receiving pensions is declining because of the deaths of existing beneficiaries and because veterans who might once have depended on VA pensions as a social safety net now have other sources of social insurance, primarily Social Security, that bring their incomes above the VA pension eligibility levels. However, the increasing average age of veterans means additional demands for medical services from eligible veterans, as aging brings on chronic conditions needing more frequent care and lengthier convalescence.

Organization of the Department of Veterans Affairs

The VA is divided into three administrative structures: The Veterans Benefit Administration, the Veterans Health Administration, and the National Cemetery Administration. VA programs are funded through 22 appropriations (including six

revolving funds receiving appropriations), nine revolving funds not receiving appropriations, two intragovernmental funds, one special fund, and seven trust funds.

The cash benefit programs, i.e., compensation and pensions (and benefits for eligible survivors); readjustment benefits (education and training, special assistance for the disabled); home loan guarantees; and veterans insurance and indemnities are mandatory (entitlement) spending, although required amounts are annually appropriated. Veterans entitlement benefits were once increasing rapidly, but now are a relatively stable federal obligation to a declining population of eligible beneficiaries, and constitute about 56% of VA spending.

The remaining programs, primarily those associated with medical care, facility construction, and medical research are annual discretionary appropriations, as are funds for the costs of administering VA programs. Unlike the ratio of entitlement spending to discretionary spending in the rest of the federal budget, the entitlement portion (income security, mostly for disability compensation, pensions, and education benefits) of VA is declining as a percent of total VA spending. In FY1976, entitlements constituted 73% of VA's budget, with the remaining 27%, discretionary appropriations for VA health care, administration, and construction. By FY1999, VA discretionary spending had risen to 45% of VA's total budget. For the entire federal budget, about one-third of spending is discretionary.

Cash benefit programs. Under entitlement programs, definitions of eligibility and benefit levels are in law. During FY1999, about 2.3 million veterans drew an average of $542 in monthly compensation for service-connected disabilities; about 303,000 of their survivors averaged about $955 in monthly payments. Pensions for 388,000 veterans averaged about $508 monthly; 283,000 survivors of veterans pensioners averaged about $212 monthly. About 38,300 veterans received readjustment education benefits, averaging $3,074 annually.

Medical care. VA operates the nation's largest health care system, with 172 hospitals, 132 nursing homes, 40 domiciliaries, 206 readjustment counseling centers (Vet Centers), 73 home health-care programs, and over 800 outpatient clinics. The FY1999 caseload was projected to increase by 160,000 veterans served over FY1998, with 54,000 more expected in FY2000; the number of different patients served by VA is projected to reach 3.6 million by FY2000. VA health care continues to place increasing emphasis on outpatient care: according to VA projections accompanying the FY2000 Budget, the inpatient caseload will be 728,000, a decline by over 50,000 patients. In contrast, outpatient visits will increase by 2.5 million to 38.3 million.

Spending Trends for Veterans Programs

Using the latest congressional estimates, federal appropriations for FY1999 for veterans programs under VA administration totaled $42.6 billion. VA spending (outlays in current dollars) increased 103% during the period FY1977-96. As a proportion of total federal spending, VA costs are going down. In FY1977, VA spending was 5% of total federal spending and 11% of spending for social welfare; in FY1996, that percentage was down to 2.5%, 5% of social welfare. Compared to the 98% increase in VA income security spending over the period, federal spending for all other income security programs increased by 284%. While VA health care

costs rose by 269%, other federal health program costs increased by 792% over the 20-year period. Appropriations for VA major and minor construction projects over the 10-year period FY1990-FY1999 averaged around $500 million per year.[1]

VA Budget and Appropriations: FY1999 and FY2000

Enacted FY1999 appropriations, and the Administration's request for FY2000. For FY2000, the Administration requested a total of $42.5 billion for VA programs.[2] P. L. 105-276, the appropriations bill for the Departments of Veterans Affairs and Housing and Urban Development (HUD), and several independent agencies, resulted in $42.6 billion in funds for VA for FY1999.

Congressional Budget Resolution for FY2000. The Administration's request for VA medical care funding assumed the continuation of the freeze in such funds that had been adopted by Congress and the President. The freeze was intended to force efficiencies in VA facilities, by causing a shift in resources from inpatient to outpatient care, thereby permitting more veterans to be served while continuing to downsize VA hospital capacity.

Criticism of the adverse effects of this policy on some regions prompted calls for increasing funding above the request, and the House approved a call for an additional $1.1 billion in its version of the Resolution; the Senate approved an additional $3 billion. Conferees settled on $1.7 billion, an amount theoretically dependent on appropriators' abilities to secure that much and remain within the overall limitations on discretionary spending imposed by the caps contained in the Balanced Budget Act of 1997 (P.L. 105-33). Each House passed a version of the FY2000 VA-HUD appropriations bill (H.R. 2684) containing $19 billion for VA medical care, which includes the $1.7 billion increase envisioned by the Resolution.

Table 1 shows appropriations for VA programs for FY1999, requested appropriations for FY2000, and appropriations included in House-passed and Senate-passed versions of H.R. 2684, FY2000 appropriations for VA (and certain other agencies). Conferees reportedly had reached agreement on H.R. 2684 late on October 7; this report will be updated shortly to reflect this latest action.

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[1] Historical spending (outlays) data are from the Historical Tables, Budget of the United States Fiscal Year 2000. *Social Welfare* is defined as budget function categories Education, Training, Employment, and Social Services; Health; Medicare; Income Security; Social Security; and Veterans Benefits and Services. *Health* is defined as the total for budget categories Health and Medicare.

[2] The VA Budget Submission for FY2000, uses different totals for FY1998 ($42.4 billion), FY1999 ($43.7 billion), and the requested amounts for FY2000 ($43.3 billion) than are shown in congressional documents supporting the appropriations process. One reason is that each new set of projections incorporate reestimates of mandatory spending for VA entitlements. In addition, there are occasional differences in accounting for carryover funds in VA home loan programs, and for receipts of the Medical Care Collections Fund (MCCF). Tables in this report use recent congressional sources.

Table 1. U.S. Department of Veterans Affairs Appropriations

($ in millions)

Program	FY1999	FY2000 request	House-passed H.R. 2684	Senate-passed H.R. 2684
Income security				
Comp.; pensions; burial	$21,857	$21,568	$21,568	$21,568
Insurance; indemnities	47	29	29	29
Education, training, and rehabilitation				
Readjustment benefits	1,175	1,469	1,469	1,469
Msc. loan, admin. exp.[a]	1	1		
Housing programs				
Current (administrative exp.)[a]	159	157	157	157
Indefinite	300	282	282	282
Trans. Housing Loans (homeless)	—	—	—	48
Medical programs				
Medical care	17,306	17,306	19,006	19,006
Transfer from MCCF[b]	(583)	(608)	(608)	(608)
Medical research	316	316	326	316
Med. admin. and misc.	63	61	61	61
Construction				
Major construction	142	60	35	70
Minor construction	175	175	102	175
Other				
Gen. Operating Expenses	856	912	886	913
Office of Inspector Gen.	36	43	39	43
Capital Asset Fund (legis. proposal)	—	10	—	—
Grants, state nurs. homes	90	40	87	90
Grants, state cemeteries	10	11	11	25
Nat'l Cemetery Administration	92	97	97	97
Total mandatory (entitlements)[a]	*23,379*	*23,348*	*23,348*	*23,397*
Total discretionary (excluding MCCF)	*19,246*	*19,190*	*20,808*	*20,954*
Total VA Appropriations	**$42,625**	**$42,538**	**$44,156**	**$44,351**

Source: FY2000 VA Budget Submission; Congressional Budget Office (CBO)

Note: rounded-may not add

a. Mandatory spending includes program payments for income security; education, training and rehabilitation; and subsidies in the home loan guarantee programs. Administrative expenses for these programs are included in totals for discretionary spending.

b. The Medical Care Collections Fund (MCCF) receives reimbursements from private insurers (whose health plans cover certain veterans who are treated by VA for nonservice-connected conditions), and copayments and deductibles from veterans ineligible for free care. This amount is not included in the totals for this table.

VA Cash Benefits. For FY1999, the current estimates are that VA paid $23.38 billion in mandatory appropriations for VA cash entitlement benefits, mostly service-connected compensation, pensions, and Montgomery GI-Bill education payments. Spending for the VA cash benefit programs is mandatory, and the amounts requested by the budget are based on projected caseloads. Definitions of eligibility and benefit levels are in law. For FY2000, current estimates indicate mandatory spending levels will reach $23.4 billion.

Medical Care. The Administration requested $17.306 billion for VA medical care for FY2000, the same level as appropriated for FY1999. House and Senate versions of the FY2000 appropriations bill (H.R. 2684) include $19.0 billion. In addition, the Balanced Budget Act of 1997 (P.L. 105-33) gave VA authority to retain net receipts of the Medical Care Collections Fund (MCCF), allowing the funds to be spent for medical services to veterans rather than be transferred to the Treasury as under previous law. Current estimates are that the change added an estimated $583 million in spending authority in FY1999, and are projected to add $608 million in FY2000.

The FY1999 appropriation for medical research is $316 million; the President's budget requests the same amount for FY2000. The Senate bill approves the request; the House bill contains $326 million for research.

For additional information on VA medical care, see CRS Report 97-786, *Veterans Medical Care: Major Changes Underway*, by Dennis Snook.

VA Construction. For FY1999, Congress provided $317 million in new construction project funding. The FY2000 budget requests construction appropriations of $235 million. The House bill includes $137 million; the Senate bill includes $245 million.

Program Administration. For FY1999, Congress appropriated $856 million for the General Operating Expenses (GOE) account for administering VA benefit programs, and $63 million for medical care administration. Estimated average employment for VA benefit programs for FY1999 is 11,273, an increase of 19 Full Time Equivalent (FTE) employees over the number of employees in FY1998. Medical staff, most of whom are engaged in patient care, is expected to continue to decline, from 188,048 in FY1998, to 185,726 in FY1999, and is expected to reach 177,831 in FY2000.

For FY2000, the Administration has requested $912 million for GOE, and $61 million for medical care administration. The House bill includes $886 million for GOE, and $61 million for medical administration. The Senate bill slightly increases the GOE account to $913 million, and slightly reduces the medical administration account (which still rounds to $61 million).

For further information on FY2000 appropriations for VA, see CRS Report RL30204, *Appropriations for FY2000: VA, HUD, and Independent Agencies*.

Veterans Issues Continuing in the 106th Congress

Veterans Medical Services: More Efficient, Greater Access

Introduction: historical trends and modern challenges. The VA medical care system is experiencing a steadily increasing number of veterans seeking care in VA facilities. VA estimates that its medical services will be given to 3.6 million different patients in FY2000, up from 2.7 million in FY1997. For the most part, these additional VA medical care obligations are being undertaken without substantially increasing appropriations to VA for its medical care programs. While the number of veterans served in FY2000 is projected to have increased by one-third since FY1997, appropriations increased by less than 2% through FY1999. Congress appropriated $17.3 billion for FY1999, and the Administration requested $17.3 billion for FY2000. Each House has passed a version of the FY2000 appropriations bill (H.R. 2684) that would increase VA health care appropriations $1.7 billion above the request, to a total of $19 billion.

To meet this challenge, VA is seeking greater efficiencies in the treatment of specific cases, increasing the number of outpatient access points, distributing resources from underutilized facilities to under-served areas, and identifying non-appropriated funds that could be used to expand medical capabilities.

Potential conflicts between medical judgements and administrative practices. VA medical care professionals and VA administrative staff are attempting to treat more veterans by achieving greater efficiencies, and without sacrificing quality of care. However, these potentially competing objectives may be difficult to reconcile, especially because the responsibility for meeting the objectives are handled differently by medical personnel and administrators. How efficiently and effectively can VA administrators manage health care resources, when resource decisions are often made by medical staff with differing objectives?

Clearly, if all 25 million veterans sought care in VA facilities, the system would be unable to meet all of the demands thereby placed upon it. On the other hand, the provision of care to specific patients depends on the access such patients have to the services of individual providers. VA medical care personnel can operate with enough flexibility in the number of patients they see, and the amount of time they spend with each patient, so that the total amount of access that can be provided over a period of time is largely indeterminable.

Reforming VA medical care to meet the challenges. The VA medical care system is traceable to the end of World War II, and rapid construction of a hospital-based system to meet the medical needs of returning troops. Over the years, all medical care became increasingly practiced in clinics and other outpatient venues. VA was slower to adapt to these changes, but in spite of rules that seemed to encourage hospitalization of veterans in order to assure their treatment, VA began to find effective care could be more efficiently provided on an outpatient basis, especially with the development of self-administered drugs to treat many conditions. To accommodate these changes in medical practice, a combination of administrative and legislative decisions made major changes to the VA health care system.

Eligibility reform. The 104th Congress reformed the rules governing access to VA health care. Until P.L. 104-262, many veterans had clear rights to acute care but not to basic services, leaving many veterans uncertain as to the medical benefits available to them, and arguably resulting in inefficient use of resources. Substantial evidence existed that demands for VA health care differed from one region to another, and the distribution of medical resources around the country did not match that demand.

Managing access. Theoretically, access to VA health care is governed through a system in which veterans are enrolled in health plans according to a schedule of priorities. These priorities are based on eligibility criteria intended to preserve sufficient resources so that high priority veterans (primarily those with service-connected conditions, or who have disability compensation ratings for such conditions), can be assured of receiving all care that might be medically indicated.

However, the medical profession views the treatment of patients' medical requirements to be the primary purpose of their decision-making process, a professional commitment sometimes in conflict with the administrative imperative of priority use of medical resources. Thus, there is always a potential conflict between the objective of medical staff to see all patients with complaints about their health, and the objective of administrative staff to manage resources to stay within budgetary constraints, while preserving resources to meet the medical needs of veterans with the highest priority for medical services.

Veterans seeking appointments may sometimes be discouraged by VA administrative staff from having their medical needs served through VA, and encouraged to seek health care services elsewhere in the community. In practice, however, all veterans presenting health complaints to VA medical facilities are screened to determine their medical condition; the disposition of most cases occurs simultaneously with that screening.

For instance, a veteran complaining of a sore throat asks to see a doctor; VA medical staff examine the patient, diagnose an infection, prescribe an appropriate antibiotic, which is then filled at an on-site VA pharmacy. If, during this screening, a patient is discovered as having an "emergent" condition (a condition, that left untreated, could threaten the health of the patient), the medical staff can be expected to initiate an appropriate course of treatment without regard to eligibility status.

In the event that the medical staff commitment to address all complaints was to come into conflict with resource limitations, VA's medical care professionals would allocate the services they could provide according to the traditional *triage* model: applicants would be given access to care based on the urgency and type of conditions presented, and those veterans most in need of care would be given high priority for services regardless of those veterans' overall place in the priority schedule administered by VA health care resource management.

This potential sharp contradiction between medical and administrative priorities has not occurred. Appropriated resources, and the shift of more services from inpatient to outpatient settings has allowed VA to serve all veterans applying for care, without denying care to any particular veteran with a medical need identified by VA

medical professionals. While some veterans have complained that services are not given to them in the same manner or location as they had previously experienced, this change is not itself a denial of care, but rather a byproduct of the efficiency efforts.

Yet, some areas of the country continue to feel the pinch of reduced VA medical resources, as programs dependent upon inpatient capacity give way to outpatient services. Shifting resources from underutilized inpatient care to outpatient clinics increases the number of veterans who can be served by the same number of VA medical personnel; 75% of the VA medical care budget funds medical care personnel, either as federal employees or through contracted care. At the same time, this shift in resources can result in the termination of programs that often rely upon inpatient capacity, especially those concerned with mental health and substance abuse programs. VA patients tend to be "older, sicker, poorer, and more likely to have social problems and mental illness than persons using private health care facilities."[3]

Regional administration. The VA reorganized the medical system into 22 regional entities, called Veterans Integrated Service Networks (VISNs). Each VISN manages all resources within the region, consolidating and integrating service capabilities to avoid duplication and increase efficiency. Annual evaluations guide the allocation among VISNs, and among units within VISNs. VA is developing unit/cost data to more accurately assess patient costs, and to identify differences in efficiencies across regions.

To provide veterans with a clearer sense of the medical benefits they could expect to receive, each VISN established health plans to administer veterans' health care — these plans began enrolling veterans October 1, 1998. Currently, all veterans applying for enrollment are accepted; this practice will continue at least through FY2000. Veterans can enroll in advance of seeking care; severely disabled are exempt from enrollment, as are veterans in a current treatment program; all others can enroll at the time they are seeking medical services.

Reallocating resources to achieve efficiencies and improve access. A system for measuring the relative needs for resources among VISNs, called the Veterans Equitable Resource Allocation (VERA), guides the shift of resources according to a methodology that identifies underutilization and rewards efficiency. According to the General Accounting Office (GAO), the objective of VERA is to provide "... comparable resources for a comparable workload ... so that veterans within the same priority categories have the same availability for care, to the extent practical, throughout the VA healthcare system." VERA is predicated on the assumption that reallocation is necessary when "... one network is allocated more funds *per veteran* than another network."

New sources of funds instead of additional appropriations. To make up the difference between appropriated funds and projected increases in medical care costs, the Administration's budgets for FY1998, FY1999, and FY2000 assumed revenues from new sources of funds. VA estimated that by FY2002, about 10% of the medical care budget could be derived from cost recovery, Medicare reimbursement, and

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[3] FY2000 VA Budget Submission, v. 2, Medical Programs, p. 2-8.

revenue from leases and service agreements. (The FY2000 Budget revises this figure downward to 7.6%, largely because the original assumption incorporated revenues from Medicare that have not been authorized.) Together with individual patient efficiency savings of 30%, VA estimated that the reforms could permit serving a 20% increase in caseload without an increase to annual appropriations. The FY2000 Budget reports that the Administration remains committed to this "30-20-10" goal.

Medical Care Collections Fund (MCCF). Veterans whose nonservice-connected conditions are treated by VA, and who are not eligible for free care[4] for such conditions are obligated to pay copayments and deductibles.[5] Also, third-party insurers, who would be obligated for at least a portion of the costs of a veteran's medical care costs if the veteran were to be treated by providers outside the VA system, are obligated to pay VA a portion of the cost of that care.

In the past, VA's MCCF fund (previously called the Medical Care Cost Recovery fund) received all medical care cost collections. Each year, VA transferred the funds to the Treasury, after subtracting the cost of administering the collection procedures. To enforce discipline on the program, and to encourage medical facilities to be more aggressive in pursuing funds VA had authority to collect, the Balanced Budget Act of 1997 requires VA to bear the costs of MCCF collections, but lets the medical program keep the funds. According to the Administration's budget, $667 million were collected during FY1998; current estimates are that MCCF will collect $583 million in FY1999, and $608 million in FY2000.

Sharing Arrangements and Enhanced Use Leases. VA medical centers have the authority to enter into sharing agreements with other health care providers in the communities in which they are located. VA is authorized to obtain services by contract whenever such contracts would be more efficient than for VA to provide the services directly. In some instances, specialized services are available from VA that other community providers seek, and VA is authorized to collect and retain fees for those services. This authority extends to support services, and some VA facilities partially offset their costs by selling such laundry or ambulance services to other health care providers.

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[4] Under current law, VA provides care free to all but about 4% of the patients it serves. Care for the treatment of all service-connected conditions is free. Care for nonservice-connected conditions is free for veterans meeting certain criteria, and most veterans with service-connected conditions can receive free care for nonservice-connected conditions as well. The largest category of veterans eligible for free, nonservice-connected care (but subject to resource limitations) have limited assets (below $50,000) and income below an annually adjusted standard (in 1999, $22,351, single; $26,824, one dependent; $1,496 each additional dependent). Veterans with incomes above $8,778 in 1999 are expected to pay $2 for each monthly outpatient prescription filled through the VA pharmacy system.

[5] For inpatient care, the amount is equivalent to the Medicare cost-sharing schedule. For 1999, veterans pay a copayment of $768 for the first 90 days of hospital care during any 365 day period, plus $10 per day; each additional 90 days requires a copayment of one-half that initial copayment, plus $10 per day; the nursing home charge is equal to the full deductible, plus $5 per day. Copayments for outpatient visits are $45.80 in 1999.

In addition, VA has temporary authority (until December 31, 2001) to enter into "enhanced use" leases, in which VA facilities can be contracted by other entities. After taking into consideration how the leasing arrangement would affect local commercial and community interests, VA can enter into the leases if it determines that the activities would not interfere with VA programs, and would in some way serve the interests of veterans. These leases may be additional sources of revenue to the facilities, and may serve to increase the use of capacity that would otherwise be underused.

Capital Asset Fund. The FY2000 Budget proposes that VA be given additional legislative authority to establish a Capital Asset Fund (CAF) that would manage the sale, transfer, or exchange of "excess and underutilized properties," with 90% of the proceeds being available for funding various projects that could make use of such underutilized properties. The remaining 10% would be transferred to the Department of Housing and Urban Development (HUD) to provide additional sources of funds for HUD homeless assistance projects. Of the VA proceeds, 5% would also be reserved for VA homeless assistance programs. The Budget estimates that the fund would realize $18 million annually in revenues from sale of surplus properties during the period FY2001-FY2004.

Medicare "Subvention". Many veterans advocates have suggested that VA should also be reimbursed for nonservice-connected care VA provides veterans who are also covered by Medicare. (Medicare *subvention*, meaning a transfer or subsidy from the Medicare trust funds, is the term by which this proposal is known.)

If Medicare were to transfer funds to cover the cost of VA's services to its existing caseload of patients who are also covered by Medicare, Medicare program outlays could increase, and VA would experience an increase in spending authority. On the other hand, if VA served *additional* veterans whose care is currently paid by Medicare, and if VA provided that care less expensively than providers who would otherwise be reimbursed through Medicare, then real savings could be possible, both to taxpayers and to Medicare. Offset against this potential savings would be any costs accrued by VA for services to additional patients, and for benefits that VA provides that Medicare does not cover for its participants, such as prescription drugs. If subvention caused the government to provide more in total services than would otherwise have been provided, overall federal spending would increase unless savings in the cost of providing those services through VA instead of through Medicare reimbursement of private health care providers equals or exceeds the cost of the additional services.

The 105th Congress considered Medicare subvention bills, but ended with no final action. One bill (H.R. 3828), to authorize a pilot project at three locations for 3 years, was reported by the House Committee on Ways and Means, with approval of the House Committees on Veterans Affairs, and Commerce. The pilot project would have permitted veterans in those three locations, whose priority status requires them to share in the cost of their medical care (called Category C veterans in the bill), to enroll in a VA plan and have their Medicare benefits provided through that plan. Medicare would then pay VA the same rate, per covered person, that it would pay for those persons to enroll in a similar private prepaid plan approved by Medicare. The bill would also have permitted veterans who live in "geographically remote areas",

and who have high-priority access to VA health care (called Category A veterans in the bill), and who are also covered by Medicare, to receive their Medicare benefits through one of VA's VISN health plans.[6]

This approach to Medicare subvention would require VA and the Department of Health and Human Services (HHS) to coordinate the collection of data, which would be analyzed to make sure that no Medicare-eligible veteran receives less in medical benefits through VA than would be received directly through Medicare, and that reimbursements to VA from Medicare do not exceed established limits. In the 105th Congress bill, Medicare would have been authorized to reimburse VA for up to $50 million in the year 2000, $75 million in 2001, and $100 million in subsequent years for care provided to Category A veterans, and $50 million for each of 3 years for the Category C veterans.

The approach had bipartisan support (with 92 cosponsors), but the 105th Congress ended with the bill not acted upon by the full House. The substance of H.R. 3828 was included in H.R. 4567, which passed the House on October 10, 1998, but no action was taken in the Senate before the end of the 105th Congress.

On February 24, 1999, the Senate passed S. 4, a bill to improve pay and retirement equity for members of the Armed Forces. Attached to the bill was an amendment to establish Medicare/VA subvention demonstrations in up to 10 sites. The proposed pilot projects would meet criteria for providing Medicare benefits through VA health care plans for certain veterans with coverage under the Medicare program. These plans would be regarded by the Medicare program as qualified Medicare providers.

On June 23, 1999, the Senate Finance Committee ordered reported the Medicare Subvention Demonstration for Veterans Act of 1999, which would establish up to eight demonstration sites to deliver Medicare-covered services to certain Medicare-eligible veterans. VA would be authorized, upon agreement with the Department of Health and Human Services (HHS), to establish an equal number of coordinated care and fee-for-service plans, one of each of which must be located within a predominately rural area. VA would provide, at a minimum, Medicare benefits equivalent to those benefits received by Medicare beneficiaries in other plans.

The Medicare Trust Fund would reimburse VA for Medicare services it provides to these dually-covered veterans by up to $50 million annually. VA would serve the Medicare-covered veterans in these plans in the most appropriate venue, whether in a VA facility, or through contracts with private health care providers. Unlike the House bill of the 105th Congress, only Category 7 veterans (those ineligible for higher priority, free VA care) could join the demonstration projects. (The House bill of the 105th Congress would have allowed enrollment in the demonstrations by veterans eligible for high-priority access to VA care, but who live in remote areas.) Other

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[6] There is no Category B. Common practice in veterans health care discussions, divides veterans into these two categories, one of which has access to free VA care, while the other agrees to share in costs. Although the categories are not found in VA law, some years ago VA law did categorize veterans according to access priority categories A, B, and C.

requirements upon VA and the Medicare program are much the same as in the House bill of the 105th Congress, and would be coordinated between VA and HHS. As of the date of this updated CRS Report, the Senate Finance Committee had not reported the Medicare Subvention Demonstration for Veterans Act of 1999.

For more on VA medical care issues, see CRS Report 97-786, *Veterans Medical Care: Major Changes Underway.*

The Millennium Health Care Act (H.R. 2116). The House has passed (September 21, 1999) the Millennium Health Care Act (H.R. 2116). The bill would expand extended care services for veterans, including geriatric evaluation, nursing home care, domiciliary services, adult day health care, non-institutional alternatives to nursing home care, home or residence assistance, and respite care. The bill would authorize the creation of such a capability to the level sufficient to assure access to the services for any veteran who needs such care for a service-connected condition, and to any veteran with a service-connected disability rated at 50% or higher.

The bill would also grant higher priority access to VA medical services for military retirees, regardless of their placement in the priority system that governs the access of all veterans to VA medical care. This change would have the effect of placing priority access for military retirees ahead of veterans who do not qualify for free, relatively high-priority care because they do not meet the standards for service-connected free care, and they do not have incomes and assets below VA's means-tested threshold. Also, veterans awarded a Purple Heart would be given access to free, higher priority health care. The bill would also authorize a pilot program for the treatment of dependents of veterans enrolled in a VA health care plan.

The bill also would raise the visibility and accountability of VA efforts to manage its extensive capital stock of buildings and other permanent medical care capability and support. VA would be required to consider alternatives and to draw upon funds for furthering these alternatives, in any situation in which a building, wing, service unit, or other facility is subject to closing. The purpose of the provisions would be to enable VA, and the communities in which the facilities are located, to determine if facilities threatened with closure could be used in some other manner to serve veterans, such as for convalescent care or other assisted living arrangements, before that building is liquidated by demolition or sale to the private sector. VA would be permitted to retain any funds obtained through leasing or selling facilities, and use such funds for the financing of other forms of disposition, including conversions of the facilities for other veteran uses.

Many of the purposes of H.R. 2116 would also be accomplished under provisions contained in S. 1076, which passed the Senate September 8, 1999. The Senate bill also contains other provisions as well, as is discussed separately in this report.

Transition from Active Duty to Civilian Life: Are Readjustment Programs Inadequate?

One of the traditional responsibilities of VA is to assist veterans in readjusting to civilian life. Readjustment assistance is also provided to service-disabled veterans to enable them to achieve maximum independence in their daily lives. As a result of the decline in the numbers of veterans, the importance of these readjustment programs is perhaps less evident than it has been during periods in which large numbers of troops were demobilized. The Veterans Affairs Committees in both Houses of the 106th Congress will review recommendations of a recent congressional commission that examined these programs.

Most of the current programs originated with the GI Bill of 1944. Under the GI Bill and subsequent additions and variations, the VA has spent over $65 billion training or educating more than 20 million veterans. Over 14 million veteran home loans have been guaranteed.

All veterans are also assured assistance in preparing for and finding employment. Educational assistance, job retention rights, preferences in federal hiring (and with employers having federal contracts of $10,000 or more per year), guaranteed direct loans, and insurance for veterans are among the kinds of assistance provided veterans. Some programs assisting in veterans readjustment are administered through agreements between VA and other agencies, including the Departments of Labor, Defense, and Transportation.

Educational Assistance. The original GI Bill was in part intended to help alleviate shortages in trained manpower, as well as provide opportunities for veterans to better adapt to civilian life. For many returning troops, the GI benefits assisted in furthering education interrupted or postponed by war service, while for others, it provided an inducement to seek training they might otherwise never have pursued. The combination of policy objectives helped both society and veterans adapt to postwar economic conditions.

The current version of the veterans education and training program, called the Montgomery GI Bill (MGIB), meets a somewhat different objective. With the end of conscription and the move to an all volunteer force, Congress enacted a program that serves as a recruiting inducement to young people considering their opportunities for future economic improvement. The Montgomery GI Bill provides educational assistance to veterans who agree to have their military pay reduced by $100 per month for the first 12 months of active duty. The money is not refundable if the participant does not elect to enroll in eligible education or training.

When the period of active duty is completed, the MGIB participant is eligible for monthly education benefits of $528 monthly for 36 months for a 3-year active duty enlistment, and $429 monthly for enlistments of less than 3 years. Other amounts may be added as inducements to join difficult to fill active duty job assignments. Other, somewhat lesser amounts may be paid to reservists, and veterans whose eligibility is traceable to an earlier program. Benefits of the MGIB program are granted a COLA each October.

Commission on Servicemembers and Veterans Transition Assistance. This congressional commission examined programs that help veterans adjust to civilian life after active duty in the armed forces, concluding that some programs "... have become so outdated, and program management so ineffective that they break faith with those who served, and currently serve, their Nation in uniform." The commission's recent report goes on to recommend "... fundamental and far-reaching reforms" to veterans programs and their administration.[7]

The commission's proposals would enforce tight performance standards on veterans employment and training programs; initiate a common framework between VA and the Department of Defense (DoD) for the resolution of disability claims; improve medical coverage for newly separating veterans; coordinate VA and DoD medical care systems; increase home loan opportunities and establish a small business loan program; and permit active duty military personnel to participate in the Federal Employees Thrift Savings Plan (TSP) on the same basis as civilian federal workers.

A proposal to increase education benefits. Perhaps the major recommendation of the Commission concerns the role VA education benefits play in recruitment of an adequate supply of young and able military personnel. At issue is a key finding of the Commission: While college attendance is a major goal of high school graduates and their parents, the value of MGIB benefits toward a college education is relatively less attractive than it once was. Other programs targeting the same population have increased in scope and generosity, causing military service to be viewed "... as a detour around college enrollment, not as a way to achieve it...Congress appropriates billions of dollars for non-veteran education programs that are available to any American without enduring the risks and sacrifices inherent in military service. A veterans' education conditioned on military service must offer a substantial advantage over programs available to all Americans ...."

The Commission proposes a substantial liberalization of the MGIB, eliminating its pay reduction in the first year of active duty, and providing a monthly stipend, funds for books, tuition, and fees "... to attend any institution of higher learning in America for which they qualify ..." to any veteran who has completed an enlistment of at least 4 years. For enlistments of less than 4 years, the Commission recommends an increase to $600 monthly, and providing the money at the beginning of an academic term.

All-Volunteer Force Educational Assistance Programs Improvements Act of 1999. On July 26, 1999, the Senate passed a bill (the House has taken no action on the bill) containing many of the recommendations of the Commission. Among provisions in the bill (S. 1402), are those which would:

- Permit benefits to be paid for preparatory courses for standardized admissions tests for college and graduate schools;

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[7] *Report of the Congressional Commission on Servicemembers and Veterans Transition Assistance,* transmitted to the Committees on Veterans Affairs, Armed Services, and National Security of The Senate and House of Representatives of the United States, January 14, 1999. The Commission was established by P.L. 104-275.

- Provide a 13.6% increase in Montgomery GI Bill benefits, from $528 to $600 monthly for 3-year enlistees, and from $429 to $488 monthly for 2-year enlistees;
- Provide a 13.6% increase for survivors' and dependents' educational assistance, from $485 to $550 monthly for full-time students, and from $242 to $274 monthly for half-time students;
- Increase Montgomery GI Bill benefits for participants who elect to increase their contributions to the program from the current required $1200 to up to $1800;
- Allow continued eligibility when enlistment is interrupted to enter Officers' Training School;
- Authorize an opportunity to buy back (for $1500) into the program during remaining active duty for those persons who had elected not to participate when they first enlisted; and
- Permit VA to make payments at the beginning of a term for veterans who would otherwise be paid monthly.

Other Veterans Issues

Veterans' Benefits Improvement Act of 1999 (H.R. 2280). On June 29, 1999, the House approved a bill that would make numerous changes to veterans benefits, incorporating into the bill the purposes of several other bills. In addition to the COLA provisions discussed above, the bill would:

- Add bronchiolo-alveolar carcinoma to the diseases presumed to be service-connected, and thus compensable. The disease is a rare form of lung cancer not associated with tobacco use, but for which some evidence is suggestive of a relationship to other contaminants encountered during service;
- Authorize the payment of Dependency and Indemnity Compensation to surviving spouses of certain former prisoners of war who died with a service-connected condition rated 100%;
- Restores eligibility for certain medical, education, and housing benefits to surviving spouses who lost eligibility for these benefits as a result of remarriage. This language restores the benefits when the second marriage ends, just as previous legislation (P.L. 105-178) restored the primary cash payment in similar circumstances;
- Expands the authority for the American Battle Monuments Commission to raise funds for the expedited completion of the World War II memorial, and authorizes up to $65 million in loans from the Treasury to begin construction;
- Directs VA to obligate a portion of FY2000 appropriations to establish 4 new national cemeteries by 2008, and to contract for an outside comprehensive assessment of future VA cemetery needs; and
- Authorizes $100 million in appropriations during FY2000-2004, for the Homeless Veterans Reintegration Program, administered by the Department of Labor under the Stewart B. McKinney Homeless Assistance Act.

Cost-of-living adjustments (H.R. 2280). With the exception of service-connected disability and survivors programs, veterans cash programs are fully and automatically adjusted each year for changes in the cost-of-living. Instead, to

facilitate the passage of other veterans legislation when Congress becomes pinched for time at the end of a session, the House and Senate Committees on Veterans Affairs report legislation each year that provides for an increase to these programs equal to the increases automatically applied to most other entitlement benefits. P.L. 105-368 provided the cost-of-living adjustments (COLA) for the service-connected disability compensation programs for CY1999, and an adjustment of 1.3% was applied beginning with checks received in January. On June 29, 1999, the House approved H.R. 2280, which provides for a service-connected compensation COLA for CY2000 benefits, equal to that provided to most other programs. On July 26, the Senate passed the H.R. 2280, after amending the bill to exclude certain provisions included by the House, and that are similar to those contained in Senate-passed S. 1076.

Arlington National Cemetery Burial Eligibility Act (H.R. 70; S. 1076). Concerns about presidential discretion to waive restrictions on burial in Arlington National Cemetery led to proposals to codify regulations on such burials. Under H.R. 70, only persons specifically covered by the bill's language could be buried at Arlington. The bill would eliminate automatic eligibility for Members of Congress, Cabinet members, and ambassadors who would not otherwise qualify because of military service. Close family members of eligible veterans could continue to be buried in the same grave with that veteran without a waiver. H.R. 70 passed the House on March 23, 1999. On July 26, 1999, the Senate approved S. 1076, with language to accomplish similar purposes contained in the provisions of H.R. 70.

Veterans Entrepreneurship and Small Business Development Act of 1999 (P.L. 106-50). On August 17, 1999, the President signed H.R. 1568, originally reported from the Committee on Small Business, to assist veterans who own, or would like to start businesses. The new law raises the profile of veterans assistance in the Small Business Administration (SBA) by creating an office specifically charged with veterans business assistance. The Office of Veterans Business Development will now oversee technical and informational assistance, and will include service-disabled veterans within the definition of "handicapped individual" for eligibility for SBA business loans. The SBA is authorized to make loans to veterans who own businesses, and who are called to active duty. Veterans are now eligible for participation in programs intended to give small business owners greater participation in federal procurement contracts. SBA will become more involved in assuring that veterans are not subject to discrimination in the startup and operation of small businesses, and that they benefit from various programs intended to improve such opportunities for veterans. Finally, SBA is required to collect data on veterans small business opportunities and successes, and report annually on veterans and their business ventures.

The Insurance Dividend: A Hoax Reappears on the Internet. The Internet has made possible the dissemination through "chain letter" postings, of numerous reports which give every appearance of being factually correct, but which are in fact, totally false. One such disseminated false "report" tells of a supposed dividend that Congress has recently enacted, and for which veterans are eligible if they apply. Rumors of this "bonus" have surfaced periodically through various forms of informal media for nearly 50 years, defying vigorous attempts by VA and Congress to eradicate it from the common sense.

Origin of the dividend rumor. In 1950, VA paid $2.7 billion in special dividends to 16 million World War II veterans who had National Service Life Insurance policies with premiums paid to 1948 (the 1948 Special Dividend). From that point forward, the possibility of dividends has led to periodic rumors that Congress has again passed such a benefit (or is considering doing so).

For instance, in 1965, for unknown reason, some newspapers published stories reporting of the special dividends that had been paid in the early 1950s, as if the dividends were being paid at the time the stories were published. While VA attempted to squash the misinformation with factual stories, each time the false reports surfaced, the stories would take on a local circulation life, gradually drifting to more marginal print media, such as newsletters, flyers, and local bulletins, and sometimes accompanied by bogus application forms. At some points, VA received as many as 20,000 inquiries per week about this supposed dividend, and in 1970 the volume of requesters prompted Congress to enact legislation declaring steps to be taken whenever VA was presented with such bogus applications.

The stories are false. There has been no recent legislation that would authorize "special dividends." Dividends are not payable to current service members insured under the Serviceman's Group Life Insurance (SGLI) or Veterans' Group Life Insurance (VGLI), both of which are group policies without dividend concepts involved. VA does automatically pay dividends on some policies of other programs that have that intended feature, but then only to veterans who have kept the policies in force. In the event a veteran is due one of these dividends, it is paid automatically on the anniversary date of the policy, and no application for the payment is necessary.

Benefits for Filipino veterans of World War II. During World War II, Filipino citizens in the military forces of the Army of the Commonwealth of the Philippines were drawn into that War under authority of U.S. Armed Forces, on the basis of legislation enacted in 1934 preparatory to Philippine independence. Many of these Filipino veterans believe that their service was active duty service in the U.S. military that should qualify them for the same benefits as other veterans of active duty. Legislation passed in 1946 specifically excludes such Filipino veterans from full veterans benefits, and pressure to amend that exclusion has periodically surfaced since that time.

Some of the Filipino soldiers were disabled during the course of their service under U.S. Armed Forces command, and became eligible for service-connected compensation from VA. Because of differences between the economies of the U.S. and the Commonwealth of the Philippines, the compensation payments were provided, under federal law, to these disabled Filipino veterans at a rate equivalent to 50 cents for each dollar that would be paid to a similarly disabled veteran in the U.S. Armed Forces, regardless of whether the Filipino veteran resided in the U.S. or the Philippine Islands.

The disparity in payments for U.S. residents entitled to VA compensation has been a recurring issue. Initially, it was argued before Congress by proponents of the lower payments that the distinction was necessary to prevent the benefits from becoming an inducement to seek residence in the U.S. solely for that purpose. Some

also argued that the Commonwealth would reach political stability more easily if these disabled veterans remained in the Philippines during the post-war period.

In recent years, Filipino advocates have pointed to the large number of Filipino veterans in the U.S. as legal residents, and have called for legislation to address their claims for full benefits. The Administration's FY1999 and FY2000 budgets have called for legislation to pay disabled Filipino veterans and their survivors residing in the U.S. the full rate, at an additional cost of $5 million during the first year, and $25 million over 5 years. Hearings in the House Committee on Veterans Affairs on the subject were held July 22, 1998, but no further action has been taken.

Supplemental Security Income (SSI) payments for Filipino veterans who have returned to the Philippines. On June 25, 1999, the House passed H.R. 1802, child welfare legislation that contained incidental amendments to the SSI program. One such change would permit the continued payment of SSI benefits to Filipino veterans of U.S. Armed Forces service during World War II, when such veterans return to the Philippines. The benefits would be paid at a level equivalent to 75% of the benefit level they would receive if they remained in the U.S. The 75% figure would make these Filipino veterans who return to the Philippines, financially about the same as they would be were they to be eligible in the Philippines for wartime service pensions from VA at the same 50% level paid for other Filipino benefits administered by VA. Veterans who are totally disabled, and who have at least one day during a period defined as wartime, are eligible for VA wartime pensions, which, like SSI, are means-tested payments. The Senate has not taken action on H.R. 1802.

The Senate has approved S. 1076, which contains, among other things, provisions to give burial rights to Filipino veterans. The House has not acted on similar legislation.

The Ongoing Issue of Presuming Service Connections: The Relationship Between Risk Exposure and Subsequent Disabilities

Introduction. Some veterans and their advocates believe that exposure to environmental toxins or unknown and mysterious diseases during military service has left many veterans vulnerable to an array of disabilities later in life. In recent times, Congress has considered the concerns of veterans with claims arising from service in nuclear testing areas, Vietnam, and the Persian Gulf. Authority for VA to provide medical treatment for diseases presumed linked to radiation has been made permanent. Similar authority to receive high priority medical treatment for diseases presumed related to exposure to Agent Orange (and other herbicides) in Vietnam expires at the end of 2002. Authority for medical treatment for veterans who may have been exposed to toxic substances or environmental hazards during the Persian Gulf War expires at the end of 2001; authority to evaluate the health of spouses and children of Persian Gulf War veterans expires at the end of this year.

Although major legislation is not expected in the 106th Congress, the issue of presuming disabilities to be service-connected, and the implications of such presumptions, is of ongoing concern to Congress and to veterans service organizations. The following discusses the history and current status of this issue.

Giving veterans the benefit of the doubt. The nation has accepted an obligation to veterans who incur injury, disease, or aggravate an existing condition (VA law calls all of these *disabilities)* while in service to the country. Health services, cash payments, and other benefits may be given to veterans who experience disabilities traceable to a period of military service. These disabilities need not have occurred in the line of duty, or even be related to active duty: for a condition to be regarded as service-connected, veterans need show only that the condition occurred (or was aggravated) as a result of military service, or arose during that period.

To receive benefits for a service-connected disability, veterans are required to document that their condition is related to their service. The claim is often clearly documented by pertinent military records. However, with some disorders, evidence of a service-connection is inconclusive. Congress has sometimes granted a *presumption* of a service-connection, so that veterans can be treated, and given appropriate compensation while scientific studies attempt to determine whether a correlation can be found between risks the veteran encountered during military service and the subsequent manifestation of a disorder.

Early in the 20th Century, these presumed service-connections permitted VA and its administrative forerunners to treat veterans for a variety of little understood ailments that they might have contracted during duty in far-off lands. While many tropical diseases long defied routine diagnosis, more familiar diseases such as malaria were diagnosed accurately, and the sporadic recurrence of its symptoms over time were well known. The passage of time between a veteran's exposure to risk, and onset or recurrence of a specific disease made the use of presumptions an attractive alternative to protracted examination of a claim that was necessarily difficult to validate or rebut.

Recent presumption issues. Current concern that latent illnesses could be related to toxic exposure during Gulf War service was preceded by similar concern that certain diseases could be related to exposure to Agent Orange or other herbicides in Vietnam. That concern was preceded by concerns that certain diseases could be related to exposure to nuclear radiation during World War II or during atomic testing in the 1950s. In these cases, policy objectives were based on the rationale that veterans should be given the benefit-of-the-doubt as to the treatment of illnesses potentially traceable to military service: (1) these veterans were sick with serious diseases needing treatment; (2) they did serve their country, often in a wartime combat zone; and (3) capacity to provide the services existed if they were given high-priority access.

From a scientific standpoint, the evidence necessary for VA to conclude that a particular presumption should be expanded to include additional diseases is not a particularly high threshold. Generally speaking, the law excludes extending presumptions to disorders in which scientific evidence has found no correlation between exposure to a risk and the contraction of a disorder, or when the disorder is attributable to another cause. Yet, other scientific evidence, even when inconclusive, may be enough for the list of disorders with a presumptive service link to be expanded.

Presumptions and exposure to nuclear radiation. From 1945 until 1963, the U.S. exploded approximately 235 nuclear devices in the atmosphere, potentially exposing an estimated 220,000 military personnel to unknown levels of radiation. Some of these veterans later claimed that low level radiation released during the testing may be a cause of certain adverse health consequences they had experienced. In addition, some veterans who had been among occupation forces in Hiroshima and Nagasaki after the atomic bomb attacks on those cities also claimed that they had experienced adverse health effects because of that occupation service.

While carcinogenic and other health effects of high radiation doses was well-known, scientific evidence about the long-term health consequences of exposure to low levels was inconclusive. In 1987, Congress chose not to "... abide by its long-standing tradition that benefits should be paid only where substantive evidence is clearly available to establish that the disabling conditions existed while on active duty or are clearly related to such period of service." Instead, Congress accepted the conclusion that because the evidence of exposure-level risk could not be verified, it should depend instead on correlation of various diseases with radiation exposure. P.L. 100-321 included language establishing a presumption that 13 diseases would be presumed to be service-connected if they manifested in veterans whose service histories included active duty in a "radiation-risk activity."[8]

The VA opposed passage of the bill, arguing that existing law was sufficient to permit awarding benefits in cases in which the evidence linking diseases to radiation exposure was conclusive. At the heart of the objection to the bill, was the Administration's claim that the "... overwhelming majority of veterans covered by [the bill] received very low doses of radiation, whether they participated in the weapons tests or the occupation of Hiroshima or Nagasaki." VA examined scientific data on correlations between various cancers and radiation exposure at the level that had been experienced by the veterans, and projected that of the 32,000 to 34,000 deaths from cancer that would otherwise occur among the 200,000 veterans made eligible for the presumption under the law, the additional exposure from their service experience would lead to 10 additional deaths.

The Administration concluded that "... the issue really becomes whether the federal government should presume that all 32,010 eventual cancers among atomic veterans are service-connected in order to assure that the 10 *possible* excess cases related to service are covered, or whether it is better public policy to look at each case individually to separate the more deserving claims from those less deserving."[9] In spite of the VA opposition, the bill passed, and subsequently has been amended to include additional diseases.

Radiation-exposed veterans continue to have various illnesses considered for inclusion within the presumption. On February 25, 1999, the Senate, before passage of S. 4, amended it to include language offered by Senator Wellstone that increased

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[8] House Report 100-235, a report from the House Committee on Veterans Affairs to accompany the Atomic Veterans Compensation Act of 1987 (P.L. 100-321).

[9] Ibid., p. 10-11

the number of diseases for which a presumption of service-connection would exist for disabilities experienced by "radiation-exposed veterans."

Expanding presumptions to include exposure to Agent Orange. Congress also granted priority medical treatment to veterans who had been exposed to the defoliant Agent Orange. The active ingredient in that defoliant is the chemical dioxin, for which there is some evidence of a disease-causing potential. By the time that Congress enacted legislation authorizing the treatment of diseases possibly linked to radiation exposure, increasing numbers of veterans of service in Vietnam were claiming a service-connection for disabilities that they believed were related to exposure to Agent Orange.

When concern mounted that exposure to herbicides in Vietnam could have posed a health risk, the Department of Defense examined its records to determine which personnel may actually have been exposed and what level of exposure they may have experienced. However, deployment records and troop movement data could not pinpoint exposure with accuracy. Congress drew the conclusion that exposure to Agent Orange (or to other herbicides, regardless of their toxicity) at sufficient levels to be potentially disease-causing had to be presumed, given the widespread use of herbicides. Because exposure to toxic herbicides was presumed for any military personnel who served in Vietnam during the period in which Agent Orange was used, science need only find some evidence suggestive of an association between a particular disease and exposure to herbicides *at any level* in order to validate a presumption that the disease is service-connected.

A presumption for Spina bifida. In 1996, Congress amended VA law to grant the presumption of a service-connection, to claims on behalf of children stricken by the disease spina bifida who are born to Vietnam veterans. Spina bifida is a birth-related disease that can entail intensive and expensive assistance to the child for years. The basis for this expansion was a National Academy of Sciences (NAS) report reviewing studies of a correlation between toxic exposure of Vietnam veterans and children born to them with spina bifida. While the scientific studies were inconclusive, NAS did find some evidence suggestive of such a correlation.

Expanding presumptions and the Persian Gulf War Syndrome. After returning from service in the Persian Gulf War, some veterans began complaining of illnesses that they thought might be attributable to their service there. Commonly reported symptoms included fatigue, muscle and joint pain, severe headaches, and memory loss. Media reports began to characterize the array of symptoms as the *Gulf War Syndrome,* although no single illness with the multitude of symptoms has been diagnosed, and no common characteristics of the veterans' circumstances have been identified other than Persian Gulf service, on land or at sea. Although a majority of ill veterans have been diagnosed with a recognized disease, a significant number remain undiagnosed, and appear to be suffering from multiple illnesses with overlapping symptoms and causes.

Congress provided for all illness claims of Persian Gulf War veterans to be examined at VA medical facilities, illnesses diagnosed whenever possible, symptoms

treated if necessary, and a data-base created to facilitate further research into causes.[10] More than 100 federally-funded research studies pertaining to Gulf War illnesses are underway. To date, clinical studies have not found an unexplained increase in deaths, hospitalizations, or diagnosed diseases among the Gulf War veteran population. No evidence has been found of a new or unique disease connected to Gulf War service.

Evidence steadily emerges that Gulf War veterans were in a complex environment, contaminated by multiple chemical substances, some of which had been introduced to improve the safety and comfort of friendly forces. Perhaps as many as 25,000 American soldiers may have been exposed to chemical weapons; while they were not actually used in combat, some believe the destruction of the weapons released toxins that may have caused illnesses with delayed symptoms. So far, medical experts report that no conclusive evidence has been presented that Persian Gulf War illnesses are related to chemical weapons, but studies of the possible effects of multiple chemical exposure, including the effects of low-level exposure to chemical weapons are underway.

The Presidential Advisory Committee on Gulf War Veterans' Illnesses. Finding that"[m]any veterans clearly are experiencing medical difficulties connected to their service in the Gulf War," the Advisory Committee reviewed numerous studies of Gulf War veterans and their health complaints. The Advisory Committee's report, dated December 31, 1996, concluded that scientific evidence had not produced "a causal link between symptoms and illnesses reported by Gulf War veterans and exposure [to] pesticides, chemical warfare agents, biological warfare agents, vaccines, pyridostigmine bromide, infectious diseases, depleted uranium, oil-well fires and smoke, and petroleum products."

Nevertheless, the Advisory Committee recommended further research in several areas, including the medical risks, especially long-term risks, that might be related to multichemical exposure, low-level exposure to chemical warfare agents, and other toxic substances with recognized carcinogenic potential that were known to be present in the Persian Gulf War. Finally, the report of the Advisory Committee emphasized the need to examine closely the relationship between wartime stress and "the broad range of physiological and psychological illnesses currently being reported by Gulf War veterans."[11]

Priority health care. Authority to provide high priority medical care for Vietnam veterans with diseases presumed linked to herbicide exposure expires December 31, 2002. Authorization for priority health care for veterans with diseases presumed linked to radiation exposure has been made permanent. P.L. 105-368 extended high priority health care for Persian Gulf veterans through 2001; expanded coverage to include treatments for veterans' dependents when their illnesses are related to the veterans' Gulf War service; and required VA to seek advice from the National Academy of Sciences on ways in which these veterans could be more effectively treated. The law also established an independent mechanism recommended

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[10] The DoD Medical Registry and the VA Persian Gulf Health Registry have had some clinical evaluation contact with about 100,000 of the nearly 700,000 Gulf War veterans.

[11] Report of the Presidential Advisory Committee on Gulf War Veterans' Illnesses. p 125.

by the Academy, so that research into Gulf War illness claims could be evaluated outside of the federal government.

Federal Research. The DoD, VA, and HHS, through the Persian Gulf Veterans' Coordinating Board, have established a comprehensive research program to provide information about the prevalence, distribution, and causes of illnesses among Gulf War veterans. According to a GAO report, federal agencies spent a total of $37 million on research on Gulf War veterans' illnesses through FY1996, and several additional projects are currently underway. (For additional information on federal research, see CRS Report 98-21, *Gulf War Veterans' Illnesses: Federal Research and Legislative Mandates.*)

Potential for adverse effects of the Persian Gulf presumptions on future scientific studies. In the absence of firm scientific evidence to the contrary, Congress has given veterans of the Persian Gulf War the benefit-of-the-doubt that their ailments may be connected to their military service. However, the basis for establishing scientifically a link between an exposure to risk and the incidence of a disease could be further eroded. Persian Gulf War veterans were potentially exposed to a large number of toxins, and are now authorized to receive priority treatment for a virtually unlimited list of symptoms. Researchers caution that it may be impossible to identify the causes of illness in many Gulf War veterans because of the absence of baseline data on the health of military personnel, and the lack of reliable data on levels of exposure to potential risks in their wartime environment. In effect, because both exposure to a toxic risk and the presence of a disorder are presumed, the statistical relationship between the risk level for one and the incidence of the other may be indeterminable.

Overcoming a presumed service-connection: tobacco related illnesses. In the 105th Congress, action was taken to prevent a service-connection to a toxic risk. After several years of study, in 1997 VA had concluded that nicotine addiction is a disease that could be linked to tobacco use that began during military service. Thus, if nicotine addiction has its origins in military service, then "secondary" diseases linked to tobacco use were arguably service-connected. While there are no actual data on the number of total possible claims, the potential number of claims was in the millions. Moreover, the "echo" of service-connected claims could have continued for decades, through compensation automatically paid to the dependents and survivors of veterans who die from service-connected conditions.

At issue was the government's responsibility when its military personnel made unwise health choices, which were at least facilitated if not openly encouraged by government actions. Some argued that American taxpayers should not be held liable for illnesses caused by veterans' decisions to use harmful tobacco products. However, as a former VA official pointed out during a recent hearing, "our veterans were in many cases provided that first cigarette by our government as part of their daily food ration or as part of a comfort pack ... clearly, the government was the agent that ultimately gave those cigarettes to our veterans."

While some veterans advocates vigorously opposed changing the law, others focused on securing some of the savings for veterans benefits. A provision restricting VA from paying compensation to veterans for adverse effects of tobacco use was

included in P.L. 105-178, the Transportation Equity Act for the 21st Century (TEA-21). A similar proposal in the President's FY1999 budget estimated the 5-year savings at $16.9 billion; $15.4 billion of that estimated savings were used to offset spending for highway projects, and the remainder was directed toward improvements in various veterans benefits.

For further information on this issue, see CRS Report 98-373, *Veterans and Smoking-Related Illnesses: Congress Enacts Limitations to Compensation*.

For further information on veterans issues in the 105th Congress, see CRS Report 97-266, *Veterans Issues in the 105th Congress*.

For issues in the 104th Congress, see CRS Report 96-141, *Veterans Issues in the 104th Congress.*